Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement for date of service 10/12/01 and 10/26/01?

   b. The request was received on 01/24/02.

II. EXHIBITS

1. Requestor, Exhibit 1:

   a. TWCC-60a/b
   b. HCFA-1500s
   c. EOBs
   d. Medical Records
   e. Reimbursement data
   f. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit 2:

   a. TWCC-60 and Response to a Request for Dispute Resolution dated 03/21/02.
   b. HCFA-1500s
   c. Reimbursement data
   d. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on 03/08/02. Per Rule 133.307 (g) (4), the carrier representative signed for the copy on 03/08/02. The response from the insurance carrier was received in the Division on 03/22/02. Therefore, the insurance carrier's response is timely.

4. Notice of Medical Dispute is reflected as Exhibit #3 of the Commission's case file.

III. PARTIES' POSITIONS

1. **Requestor:** Per the TWCC-60b, "We feel that we the provider should be reimbursed in full for the medical equipment we provided this patient with. We obtained Pre-Authorization per Rule 134.600 and we should have been reimbursed in full."

2. **Respondent:** Per letter dated 03/21/02, "…there was neither a pre-negotiated amount nor an appropriate 'D' code for the equipment provided by the requester. Consequently, the Carrier relied on Medicare's 1998 Region C DMEPOS Fee Schedule to determine the fair and reasonable rates for an population of equivalent standard of living."

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) & (2), the only dates of service eligible for review are 10/12/01 and 10/26/01.

2. The carrier's EOBs use the denial code "M – THE REIMBURSEMENT FOR THE SERVICE RENDERED HAS BEEN DETERMINED TO BE FAIR AND REASONABLE BASED ON BILLING AND PAYMENT RESEARCH AND IS IN ACCORDANCE WITH LABOR CODE 413.011(B)."

3. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	BILLED	PAID	EOB Denial Codes	MAR$	REFERENCE	RATIONALE:
10/12/01 10/26/01	E1399 E1399	$239.00 $239.00	$55.00 $120.00	M M	DOP DOP	Texas Workers' Compensation Act & Rules, Sec. 413.011(d), Rule 133.304(i)	Due to the fact that there is no current fee guideline for the service provided, the Medical Review Division has to determine based on the parties' submission of information, which party has provided the more persuasive evidence of what represents fair and reasonable reimbursement. The carrier's determination of fair and reasonable is based on a DME equipment catalog which indicates the product is available for $120.00. This documentation is more persuasive, than the three EOBs from other carriers submitted by the provider. The carrier's documentation indicates that $120.00 is fair and reasonable reimbursement and conforms to the criteria of Sec. 413.011(d) of the Texas Labor Code, "…to achieve effective medical cost control." The provider is entitled to additional reimbursement of $65.00 ($120.00 less $55.00 reimbursed) for date of service 10/12/01 and no additional reimbursement for date of service 10/26/01.

10/26/01	E0748	$5000.00	$3342.55	M	DOP	Texas Workers' Compensation Act & Rules, Sec. 413.011(d), Rule 133.304(i)	Due to the fact that there is no current fee guideline for the service provided, the Medical Review Division has to determine based on the parties' submission of information, which party has provided the more persuasive evidence of what represents fair and reasonable reimbursement. The carrier's determination of fair and reasonable is based on the Medicare's 1998 Region C DMEPOS Fee Schedule and is more persuasive, than the three EOBs from other carriers submitted by the provider. The carrier's documentation indicates that $3342.55 is fair and reasonable reimbursement and conforms to the criteria of Sec. 413.011(d) of the Texas Labor Code, "…to achieve effective medical cost control." Therefore, no additional reimbursement is recommended.
Totals		$5478.00	$3517.55				The Requestor entitled to additional reimbursement in the amount of $65.00.

V. ORDER

Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Medical Review Division hereby ORDERS the Respondent to remit $65.00 plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this order.

This Order is hereby issued this 17th day of April, 2002.

Larry Beckham
Medical Dispute Resolution Officer
Medical Review Division

This document is signed under the authority delegated to me by Richard Reynolds, Executive Director, pursuant to the Texas Workers' Compensation Act, Texas Labor Code Sections 402.041 - 402.042 and re-delegated by Virginia May, Deputy Executive Director.